2022 IU Health Provider Option Form

Indiana University Health

IMPORTANT Instructions (Failing to completely follow instructions may result in loss of incentive points):

1. Bring this form to your appointment.
2. To earn incentive points, complete **ALL** fields of this form.
3. Make sure you and your provider sign the form.
4. YOU, not your provider, are responsible to submit this form. (Forms must be **received** by **Nov. 30, 2022)**
   - **a) Submit online at https://www.totalwellnesshealth.com/gravity-landing/iu-health-pof-online-upload/**
   - **b) Fax securely to 402.881.8422**
   - **c) Mail to TotalWellness, Attn: Data Team, 9320 H Court, Omaha, NE 68127**
5. Save your original form and proof of submission, either email receipt, fax receipt or USPS certificate of mailing.
6. You should receive a confirmation email within 5 business days after you submit this form. If you don't receive a confirmation, resubmit your form one time only.

PARTICIPANT INFORMATION:

First Name:

Last Name:

Last 4 Digits of SSN

Primary Phone Number: ___ — ___ — ____

Date of Birth: (mm/dd/yyyy) __ / __ / ____

Email: *(Required to provide you confirmation of receipt for this form)*

Gender: ○ Male ○ Female

Have you fasted for at least 8 hours? *"No Food. Only water and black coffee permitted."* ○ Yes ○ No

BIOMETRIC INFORMATION

Date of Screening: (mm/dd/yyyy)	**Height:** Ft.	Inches	**Weight:** Lbs.	**Waist Circumference:** Inches	**Blood Pressure:** Systolic	Diastolic
__ / __ / ____			____.__		____ /	____

Total Cholesterol:	**HDL:**	**Ratio TC/HDL:**	**LDL:**	**Triglycerides:**	**Glucose:**	**HbA1C:**
		__.__				__.__

Provider Name:_____ Provider Phone Number:_____

Provider Signature:_____

Consent Information: This information along with any personal health information provided in completing the Health Survey is maintained in a secure area within the Wellness Department to be used only for calculating incentives for Indiana University Health Plans and/or the Healthy Results program and is not shared with your immediate supervisor. Healthy Results will provide my employer aggregate information as part of a group summary report (individual data will not be disclosed.)

IU Health uses some of its subsidiaries and affiliates to carry out the work of its wellness program. To the extent it is necessary for these agents, employees and/or clinical providers of IU Health to have access to my health screening information in order to carry out their duties.

By submitting this form, I hereby consent to this use of my health screening information and grant any such wellness program associate permission to contact me regarding my results.

I understand that TotalWellness may utilize the above health information to track participation and provide me with health guidance. This information will be used to provide confidential services to me and to gather anonymous statistical data for my company. I understand that my basic statistics will be aggregated and presented in reports only to show trends in health conditions and use of services. No personal health information will be provided to my company. Biometric data or personal identifiers (i.e. date of birth, name, etc.) may be transferred to a 3rd party for reporting and/or incentive tracking.

I certify that the information supplied on this form has been provided to me by my health care provider, and TotalWellness may contact my provider regarding the information.

Participant Printed Name: _____

Participant Signature: _____ Date: _____

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